As Approved

HOSPITAL AUTHORITY OF ALBANY-DOUGHERTY COUNTY, GEORGIA

MINUTES OF FEBRUARY 16, 2012 MEETING
(Open Session)

Attendees: Authority Board Members: Ralph Rosenberg; Dr. Charles Lingle; Dr. John Inman, Jr.; John Hayes; Lamar Reese; Fred Ghiglieri; Dr. Steven Wolinsky; Legal Counsel: James E. Reynolds, Jr., also present were: Joel Wernick; Kerry Loudermilk; Joe Austin; Tommy Chambless; Tom Sullivan; Dr. Price Corr; Dr. Doug Patten; and Recorders, Annette Allen and Mary Barfield

Absent Authority Members: Dr. Eugene Sherman; Rev. H. B. Johnson

Call to Order:

The meeting was called to order by Chairman Rosenberg at 7:30 A.M. in the Board Room of Phoebe North Hospital.

Open Meeting and Establish a Quorum:

Mr. Rosenberg welcomed the Authority and established that a quorum was present, with seven members being in attendance.

Approval of the Agenda:

The proposed Agenda was reviewed and a motion made by Dr. Lingle and seconded by Lamar Reese, to adopt the Agenda as presented. The motion was approved by the Authority.

Approval of the Minutes:

The Minutes of the January 19, 2012 meeting, having been provided to the Members prior to the meeting, were presented for approval. A motion was made and seconded to approve the Minutes as provided. The motion passed unanimously.

Closing of the Meeting:

A motion was made by Dr. Lingle and seconded by Dr. Wolinsky to close the meeting in order to (i) discuss the granting, restriction or revocation of staff privileges at Phoebe North; (ii) discuss pending litigation with legal counsel; and(iii) discuss potential commercially valuable plans and proposal or strategy that may be of competitive advantage in the operation of Phoebe North and/or PPMH or their medical facilities .

Mr. Rosenberg polled the individual Authority Members whose votes are shown below:

Ralph Rosenberg	Yes
Dr. Charles Lingle	Yes
Dr. John Inman, Jr.	Yes
Fred Ghiglieri	Yes
Lamar Reese	Yes
John Hayes	Yes
Dr. Steven Wolinsky	Yes

The motion having passed, the meeting was closed.

Open Session Reconvened:

Dr. Wolinsky and Dr. Corr had by this time been called away from the meeting.

Staff Privileges:

Because Dr. Corr had been called out of the meeting, Dr. Patten stepped in for him to make the presentation of the recommendations of the Phoebe North Medical Staff. After the presentation, a motion was made by Dr. Lingle and seconded by Dr. Inman to accept and approve the Medical Staff recommendations for the credentialing of certain Phoebe North Medical Staff as presented by Dr. Patten. A copy of the recommendations as approved is attached.

Financial Reports:

Kerry Loudermilk made a presentation of certain interim financial reports for Phoebe North and the Authority. A copy of the presentation is attached hereto.

Phoebe North Operations Report/Environment of Care Report

A presentation was made by Tom Sullivan, Chief Transition Officer, regarding the

operation of and planning for Phoebe North. A copy of the presentation is attached to these minutes.

Mr. Sullivan's reports included the Environment of Care report for Phoebe North. The EOC report included six chapters of standards as set forth by the Joint Commission Accreditation Hospital Organization and other federal and state agencies. A copy of the EOC presentation is separately attached.

Mr. Sullivan also noted that a memorial service was held at Phoebe North for Allen Golson on February 9, 2012. He was recognized for his service as CEO of Palmyra Medical Center from 1995-2005.

Reports from Phoebe Putney Memorial Hospital

Mr. Wernick gave a report principally pertaining to the operations of and plans for Phoebe North and PPMH. No written report was submitted.

Mr. Wernick concluded by mentioning that Dr. Gray Rawls recently died and that the Authority, along with PPMH, might wish to cause some tribute or recognition to be made in honor of Dr. Rawls for his service to the Authority, PPMH and the entire community, which included his having served as the first physician Member of the Hospital Authority.

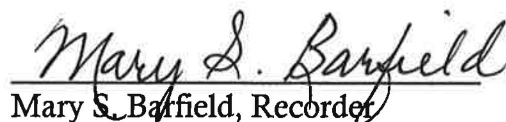
Old Business:

Mr. Rosenberg observed that the Authority would likely continue to hold Authority meetings on a monthly basis for the foreseeable future, to deal with the additional issues resulting from the operations of Phoebe North.

It was reported that a small office for the Authority would be established and located at the Phoebe Memorial Hospital Third Avenue campus, in close proximity to the Willson Board Room. This office would contain all records of the Authority and generally the office will be locked, but certainly it will be available to Authority Members by logging in and obtaining a key.

Adjournment:

There being no further business, the meeting adjourned at 9:30 A.M.



Mary S. Barfield, Recorder

AGENDA
HOSPITAL AUTHORITY OF ALBANY-DOUGHERTY COUNTY, GEORGIA

Meeting of February 16, 2012
7:30 A.M.
(Phoebe North Campus)

I.	Open meeting and establish quorum	Ralph Rosenberg
II.	Approval of Agenda	Ralph Rosenberg
III.	Consideration of Minutes of January 19, 2012 meeting (Draft previously provided to Members)	Ralph Rosenberg
IV.	Motion and vote to close meeting in order to (i) discuss the granting, restriction or revocation of staff privileges at Phoebe North; (ii) engage in privileged consultation with legal counsel; and, (iii) to discuss potentially commercially valuable plans, proposal or strategy that may be of competitive advantage in the operation of Phoebe North and/or PPMH or their medical facilities. Consideration of any official action to be taken following the re-opening of the meeting.	Ralph Rosenberg
V.	Presentation of Medical Staff recommendation pertaining to credentialing of Phoebe North Medical Staff and consideration thereof by the Board	Dr. Price Corr
VI.	Presentation of interim financial reports on behalf of Phoebe Putney Memorial Hospital, Inc. and on behalf of Authority	Kerry Loudermilk
VII.	Phoebe North Operations Report/EOC Report; Consider approval of EOC Report	Tom Sullivan
VIII.	Report on behalf of PPMH, Inc.	Joel Wernick
IX.	Old Business	Ralph Rosenberg
X.	Adjournment	Ralph Rosenberg

Credentialing Appointments-February 2012
Phoebe North

Initial Appointments		
Name	**Type**	**Specialty**
Samir Patel	MD	Emergency Medicine
James Sinnott	MD	Gastroenterology
Edgardo Belocura	NP	Oncology
Traci Yawn	NP	Oncologic Surgery

Re-Appointments		
Name	**Type**	**Specialty**
Gordon Appelbaum	MD	Emergency Medicine
Robert Bloing	MD	Anesthesia
Bryan Carducci	MD	Emergency Medicine
Moon Chung	MD	OB/GYN
Jon Durham	DPM	Podiatry
Stacy Evans	MD	Pediatrics
Kenneth Gargan	MD	Radiology
Ayodeji George	MD	Hospitalist
Jason Hester	MD	Pediatrics
Dennis Holwerda	MD	Pediatrics
James Hotz	MD	Internal Medicine
Chirag Jani	MD	Hem/Onc
Michael Labanowski	MD	Tele-Rad
Kara Marcantel	MD	Tele-Rad
William McAfee	MD	Radiation Oncology
Robert Paduano	MD	Pediatrics
Paul Peach	MD	Physiatry
Cullen Richardson	MD	General Surgery
Harold Schwab	MD	Emergency Medicine
Chris Smith	MD	General Surgery
Stephen Wilder	DPM	Podiatry
Steven Wolinsky	DO	Cardiology
Steven Yang	MD	Gastroenterology
Cindy Caldwell	NP	Bariatrics/ED
Tiffany Levins	PA	Internal Medicine

Other Credentialing		
Name	**Type**	**Specialty**

Resignations			
Name	**Type**	**Specialty**	**Effective Date**
Charlotte Charfen	MD	Emergency Medicine	1-16-12
Edward Oleen	MD	Hem/Onc	4-1-12
Sheela Shah	MD	Hospitalist	1-11-12
James Underwood	CRNA	Anesthesia	2-20-12
Wun Augustin	PA	Emergency Medicine	1-10-12

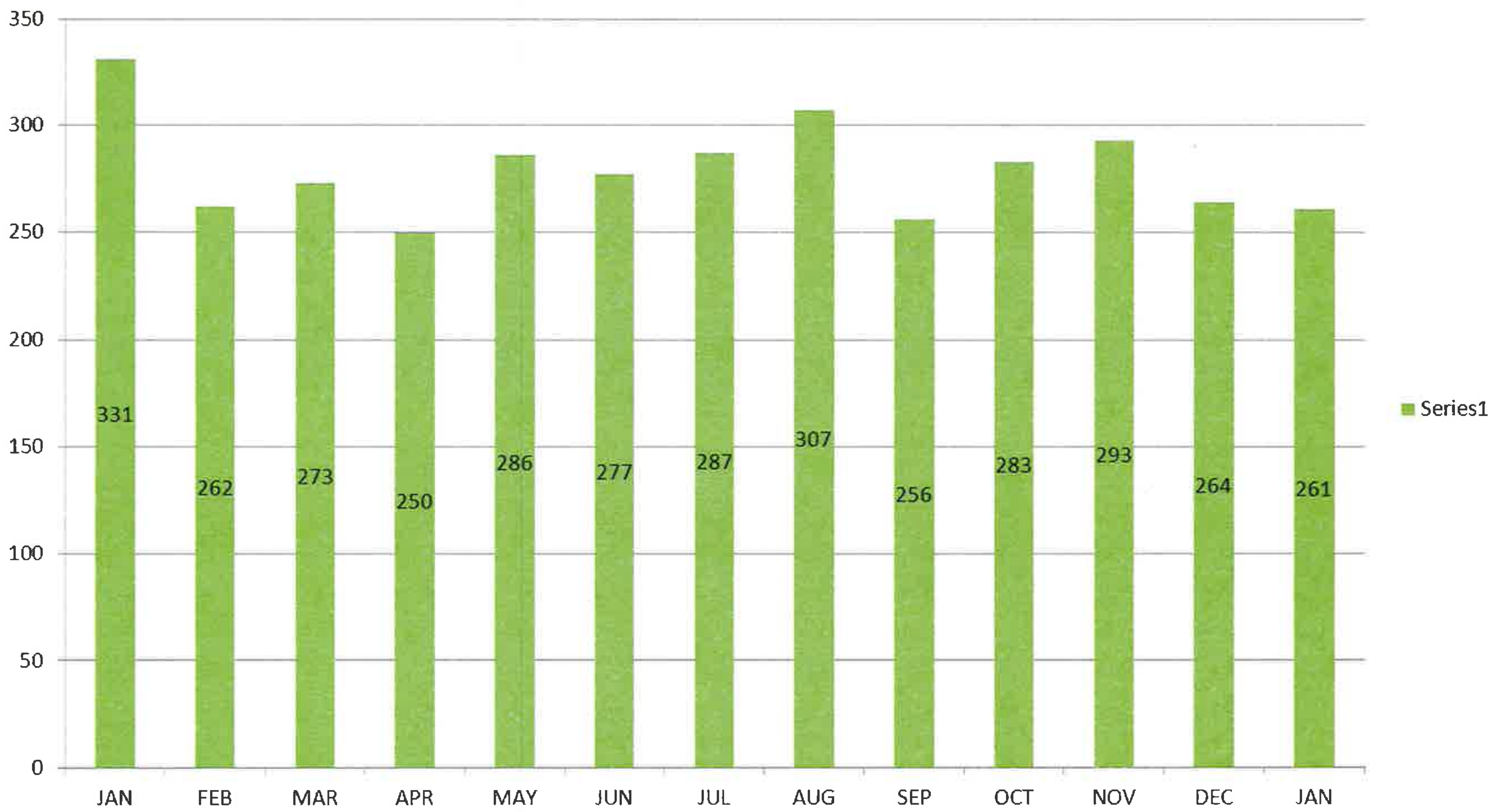
Leave Of Absence		
Name	**Type**	**Specialty**

Phoebe North

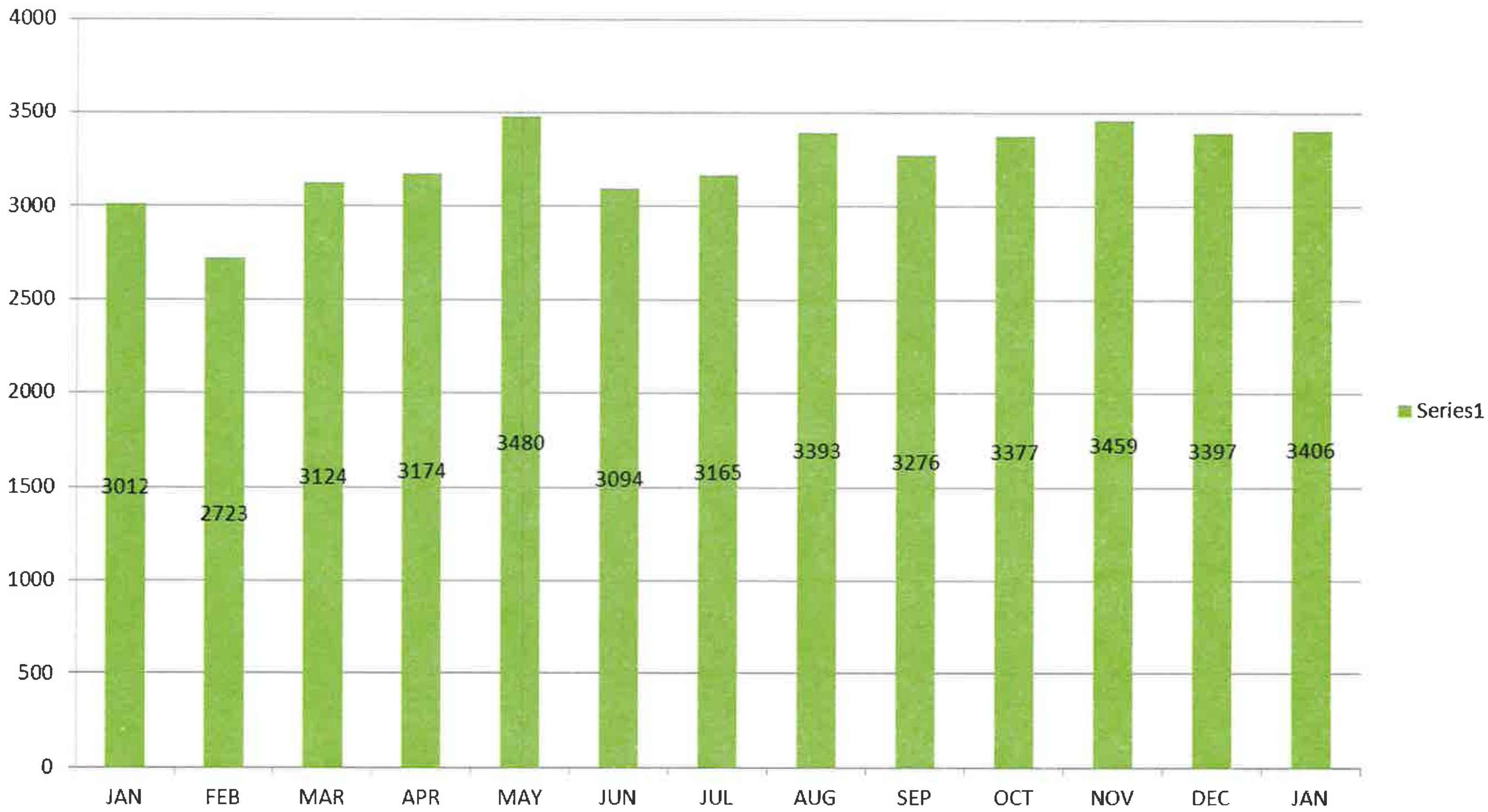
FY2012 Operating Indicators

January

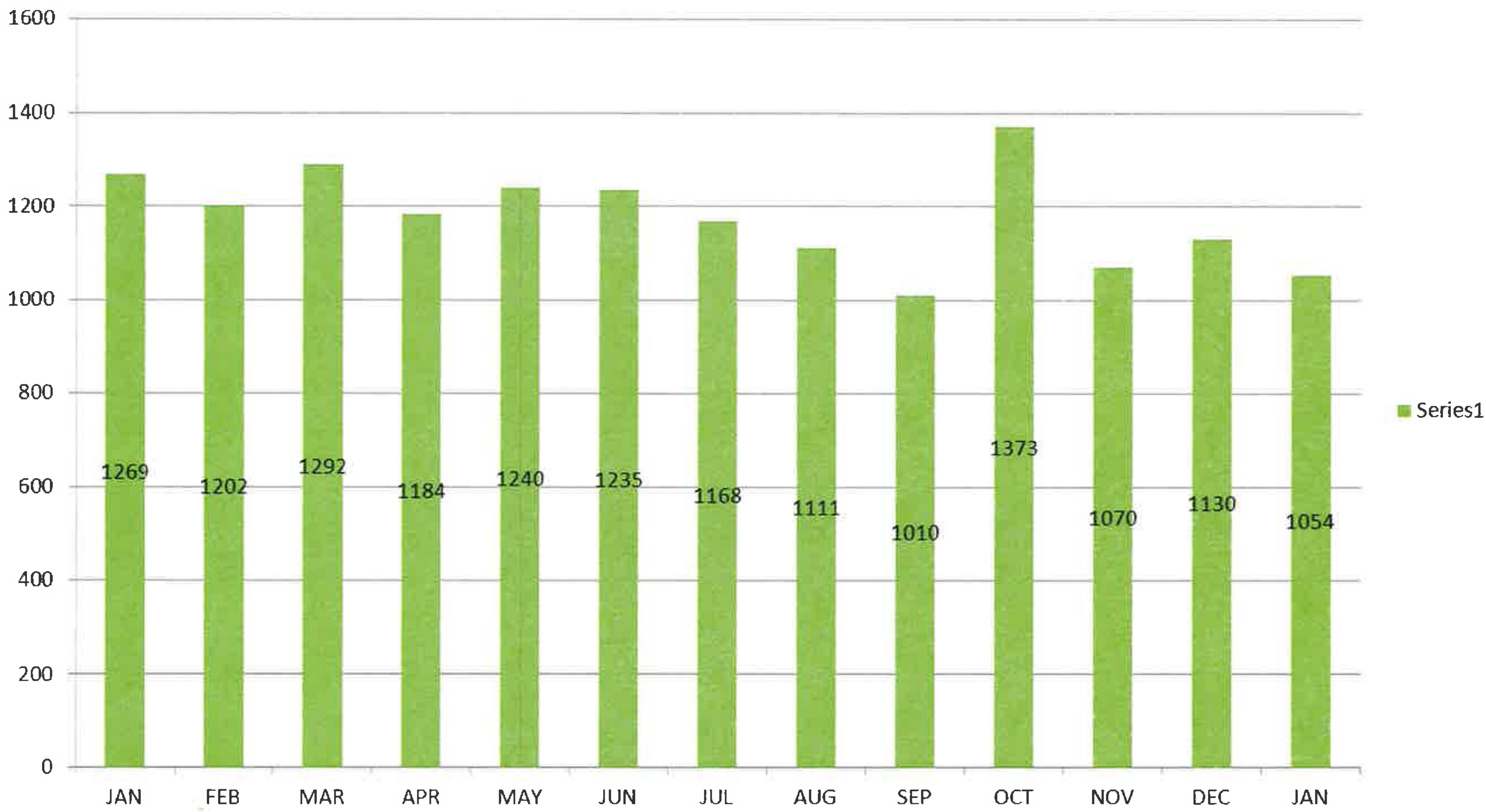
Admissions



ER Visits



Outpatient Visits



FTE's

Financial Update

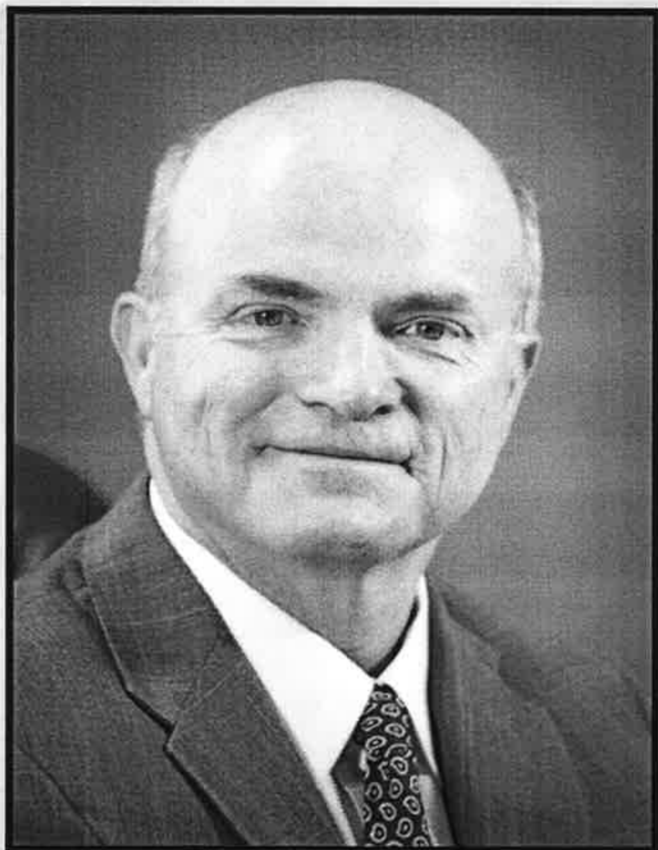
Financial Outlook

Jan-12

	Jan Actual 2012	**Budget 2012**	**Variance**
Gross Patient Revenue	21,215,185	23,369,874	-9.22%
Other Operating Revenue	78,487	58,957	33.13%
Deductions	16,117,223	17,968,434	-10.30%
Net Revenue	5,176,449	5,460,396	-5.20%
Operating Expenses	5,092,512	5,863,550	13.15%
Operating Income (Loss)	83,937	(403,154)	79.18%

Hospital Authority of Albany-Dougherty County BOARD MEETING

February 16, 2012



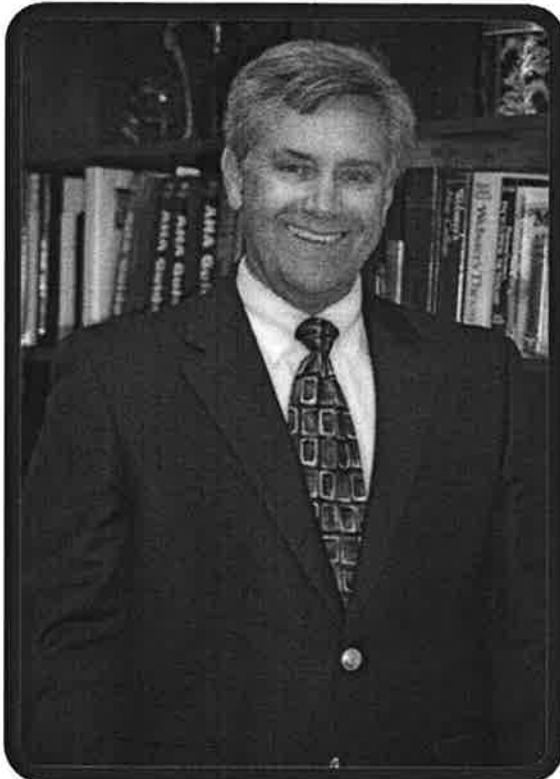
Allen Golson
CEO Palmyra Medical Center
1995-2005
Memorial Service 2-9-12

EMPLOYEE ENGAGEMENT

- Meetings and Rounding – Counterparts/Administration
- Administrator on Call began January 30, 2012
- PEACH and United Way
  - ✓ 125 Employees Enrolled
- Healthworks Membership
  - ✓ 141 Employees Enrolled
  - ✓ 26 Spouses Enrolled
- *Y'All Come*
  - ✓ February 21, 2012

Community Engagement & Tour

Gwen Collins, RN, Director of Education
Martin Luther King Event



Eric Riggle
Director of Marketing
Martin Luther King Event

Phoebe North Staff at Carlton Breast Center

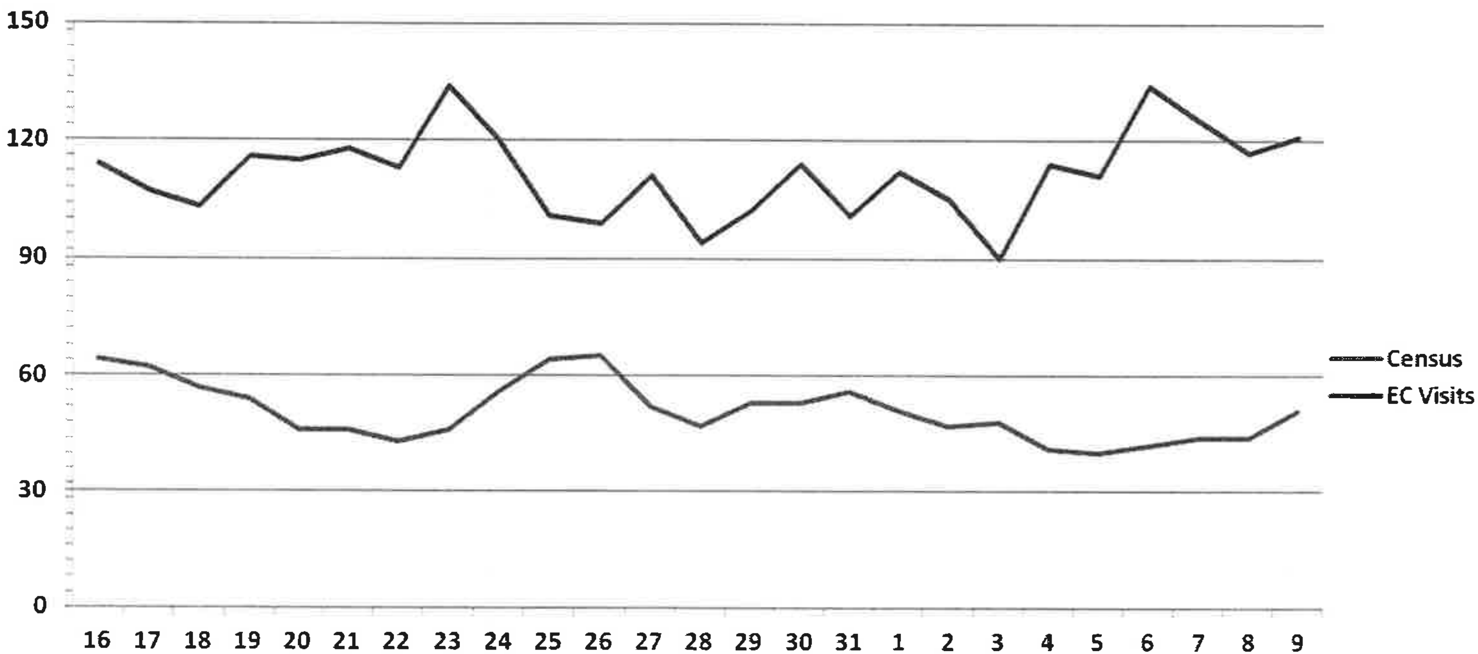
OPERATIONAL UPDATE

- Press Ganey Customer Satisfaction
- Emergency Department – Schumacher
- Patient Safety Initiative
- WOW and ICARE

OPERATIONAL UPDATE cont.

- **Office Manager's Council – February 9**
  - Women's Health Professionals, SW Ga Pediatrics, Prestige Pediatrics, Albany Surgical, MSA, Premier Orthopedics, Albany OBGYN, Jeff Davis Office, Albany ENT, Albany Vascular, Albany GI, Veranda, Eye Center South, Family First Practice, South Ga Urology, Dixon Eye Care, Surgical Associates of Albany, Lung Diagnostics

CENSUS TRENDS



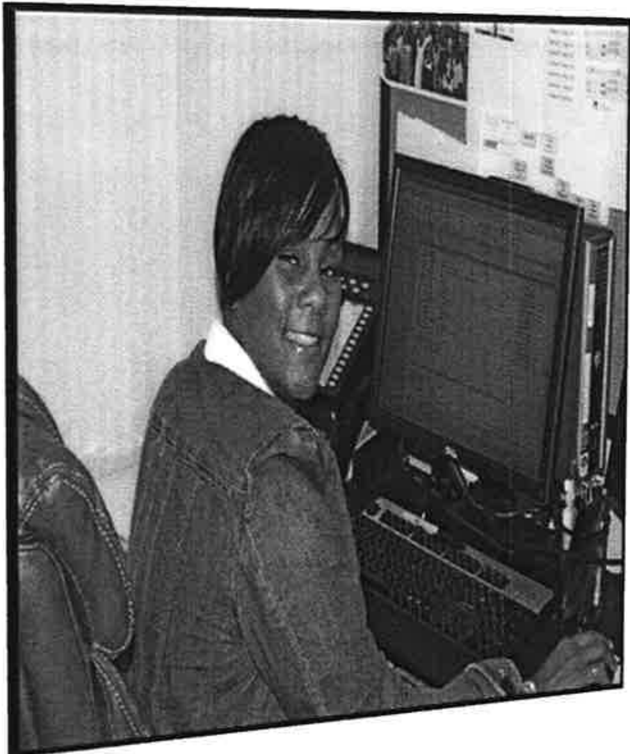
Jan-Feb	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	1	2	3	4	5	6	7	8	9
Census	64	62	57	54	46	46	43	46	56	64	65	52	47	53	53	56	51	47	48	41	40	42	44	44	51
EC Visits	114	107	103	116	115	118	113	134	120	101	99	111	94	102	114	101	112	105	90	114	111	134	125	117	121

MANAGEMENT STRENGTH

Anita West, Director of Centralized Scheduling

Lisa Pinkston, Director Lab and PPMH Guest Relations

CONSOLIDATION & EFFICIENCY



Tyron Williams
Phoebe North HR Manager

Lori Perry, Risk Manager

ENVIRONMENT OF CARE

- Review EOC Annual Report
- Management Recommendation to approve the Annual Report

- **PHOEBE PUTNEY HEALTH SYSTEM UPDATE - Joe Austin**

Accredited with Commendations
by the American College of Surgeons

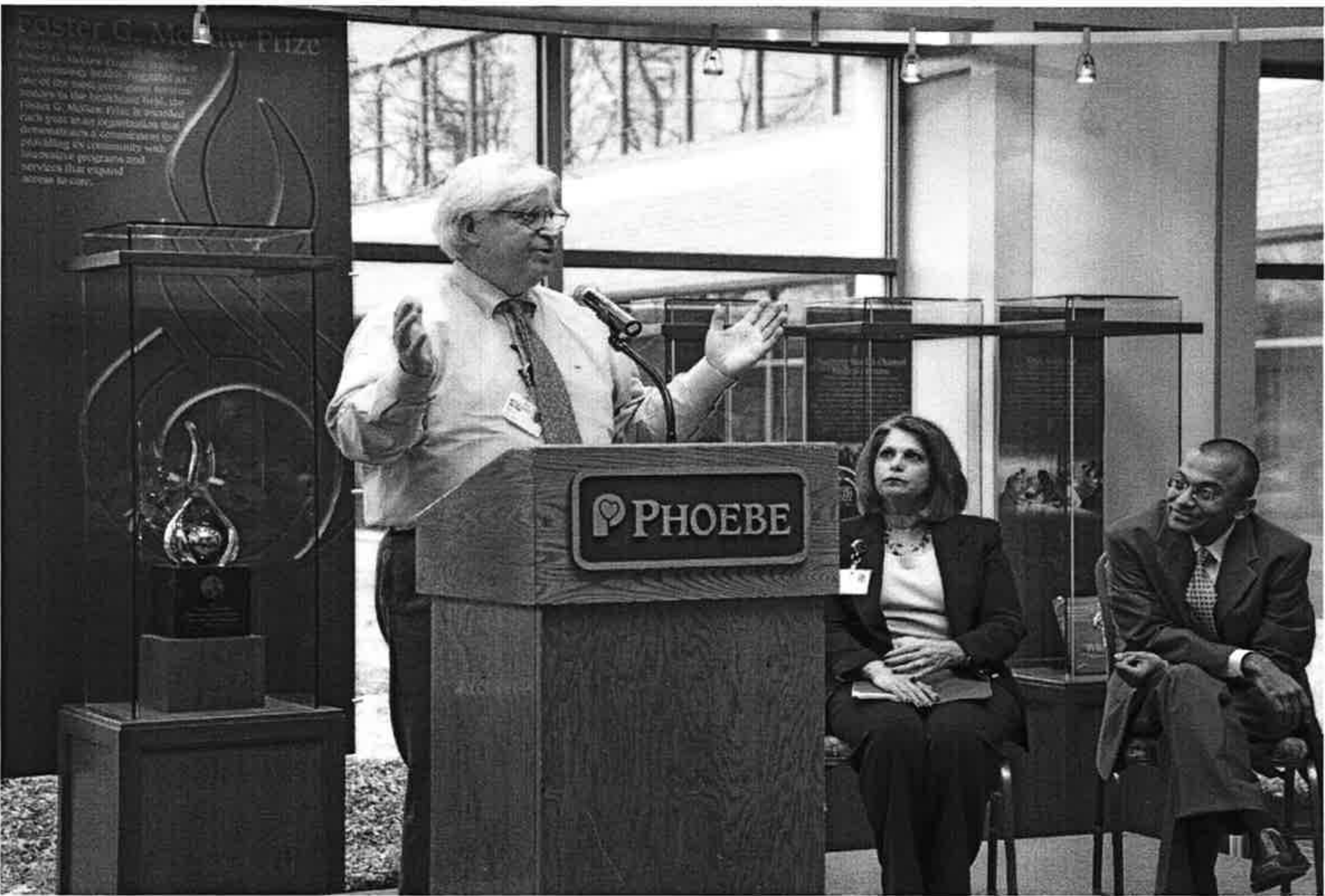
Breast Imaging Center of Excellence

Breast Cancer Center of Excellence

NAPBC

National Accreditation Program for Breast Centers

PHOEBE CANCER CENTER NEWS CONFERENCE



Meredyth Campus
MOB II Status

February 14, 2012

EOC SUMMARY

About the Joint Commission

The Joint Commission Accreditation Hospital Organization (JCAHO) is a private, not –for-profit organization dedicated to continuously improving the safety and quality of care provided to the public. The JCAHO is the nation's principal standards setter and evaluator for a variety of health care organizations, including hospitals, critical access hospitals, ambulatory care organizations, behavioral health care organization, home care organizations, and other healthcare facilities.

Environment of Care is one of the many sections of standards set forth by the Joint Commission.

Environment of Care

The Environment of Care is made up of six chapters of standards that are regulated by Joint Commission Accreditation Hospital Organization (JCAHO) and other federal and state agencies. This is a summary only of the six chapters. Detailed information of all measured indicators can be found in each annual plan evaluation of the previous calendar year.

1. **Bio-medical Equipment Management**

   The objective of the medical equipment management plan is to manage medical equipment risks and promote the safe and effective use of medical equipment. The objective has been met as evidenced by the following indicators:

   PM compliance of 96.9% which is above the threshold of 95%

   Can Not Locate (CNL) percent decreased from 1.4% in 2010 to .9 % in 2011.

2. **Safety Management**

   The objective of the Safety plan is to identify inherent safety risks associated with providing services for patients, the performance of daily activities by staff, and the physical environment in which services occur and plan and implement processes to minimize the likelihood of those risks causing incidents. The objective has been met as evidenced by the following indicators:

   Safety education and training 100 % compliant

   Product recall monitoring 100%

   Construction assessments 100%

3. **Security Management**

   The objective of the Security Management plan is to provide a safe environment for the buildings, grounds, equipment, services, and staff of the organization, as well as our patients, visitors, vendors, contractors, and the general public who use our facilities. The objective has been met as evidence by the following indicators:

Additional Lighting added to rear Staff parking lot

Lock-Down system added to all outer entrance doors

Spot-light added to Security car

Adjusted Security schedule for better overall coverage and efficiency

Security grounds inspection completion rate 100%

4. Fire/Life Safety Management

The objective of the Life / Fire Safety Management Plan is to design proactive processes to prevent fires and protect patients, staff, visitors and property in the event of a fire. The objective has been met as evidenced by the following indicators:

Average fire drill score is 88% which has increased from 85.4% from prior year.

Wall penetrations decreased due the implementation of above ceiling permit and ongoing Building Maintenance Program (BMP)

5. Hazardous Materials and Waste

The objective of the hazardous Materials and Waste Management plan is to provide a safe environment for the buildings, grounds, equipment, services, and staff of the organization, as well as our patients, visitors, vendors, contractors, and the general public who use our facilities. The objective has been met as evidenced by the following indicators:

Achieved 100% compliance with completion of departmental chemical inventory

Provided education for staff at orientation, on 'update and educate' in Healthstream, and as needed from occurrence reports, environmental rounds, etc

6. Utilities Systems Management

The objective of the Utilities Systems Management plan is to assess and minimize risks of utility failures, promote a safe, controlled, comfortable environment of care; ensure operational reliability of the utility systems. The objective has been met as evidenced by the following indicators:

Weekly rounding through mechanical spaces to ensure proper equipment operation is 98%.

Isolation valves and zone valves were added to Medical Gas systems for 100 % compliance.

BIOMED PLAN
#1

2011 Annual Evaluation
Palmyra Medical Centers
Medical Equipment Management Plan

Scope

The scope of the Medical Equipment Management Plan encompasses all required processes as identified in the appropriate Joint Commission, NFPA, OSHA, and other applicable regulatory codes and standards. The scope also includes all of the buildings, grounds, equipment, services, and staff of the organization, as well as our patients, visitors, vendors, contractors, and the general public who use our facilities.

Considering the Joint Commission Standards for 2012, it appears that the majority of the changes for Medical Equipment Management are minor in nature (e.g., simplification of monitoring/improvement requirements, etc.). As such, further revisions in scope should not be required based on these changes.

In addition, there have not been any changes to other applicable laws and/or regulations or to the organization and/or its mission that would necessitate further changes in scope to the Plan.

Objective(s)

The basic objectives of the Plan for last year were to:

- Manage medical equipment risks; and
- Promote the safe and effective use of medical equipment by ensuring that:
    - Equipment is appropriate for the intended use;
    - Staff members are trained to use the equipment safely and effectively; and
    - Qualified individuals maintain equipment appropriately.

These are still considered to be valid objectives for the upcoming year.

In determining the overall effectiveness of the Plan and the effectiveness of the Plan in relation to the stated objectives, the following elements and/or program outcomes will be evaluated

- Medical equipment selection and acquisition process;
- Risk/Inventory Criteria
- Inspection, Testing, and Maintenance Strategies, Intervals, and Outcomes as appropriate;
- Safe Medical Devices Act Monitoring and Reporting activities
- Medical Equipment Emergency Procedures Education
- Life support equipment

- Education/Staff Competence;
- Monitoring, reporting, & investigating medical equipment incidents.

The Objectives have been met for 2011 as evidenced by the following information.

Performance

Overall, the processes utilized in the Plan worked well as evidenced by the Program outcomes delineated herein. There are, however, some areas that deserve note.

- The Medical equipment selection and acquisition process was followed as is evident in the number of devices added (71) through normal process rather than found in use which was (8) devices. This process will continue in the coming year and we will continue to educate staff for re-evaluation in 2012. See Attachment No 1 and 2.
- The Risk/Inventory Criteria is established by GE Healthcare and agreed upon by the facility. This process is monitored and modified annually by both parties through a Transaction Schedule. This evaluation was completed and signed by Steve L. Woodford, CFO on 8/8/2011. See Attachment No 3.
- The inspection, testing, maintenance strategies, intervals and outcomes of equipment are evaluated on a daily basis and reported to the EOC committee on a monthly basis. PM compliance for 2011 was 96.9%, which was above the 95% threshold. 987 work orders were opened and 944 were closed. There were 74 Could Not Duplicates (38 in 2010), 25 Operator Errors (41 in 2010) and 48 Physical Damaged items (30 in 2010). See Attachment No 2.
- In order to insure compliance with the Safe Medical Device Act, GE Healthcare issues a monthly Risk Management Newsletter. A report including any identified equipment with corrective action is submitted to the EOC committee no less than bi-monthly. There were 5 devices affected by an alert but no devices were removed from service in 2011 due to being unsafe. See Attachment No 4.
- The department personnel in the facility are educated to follow the GEHC procedures for the replacement of medical equipment when it fails.
- The EOC committee evaluates the facility Life Support Equipment List annually. The equipment is 99.6% compliant for the year 2011. This was due to defibrillators being left on the crash carts and stored in non-accessible places while a department is shut down. This problem will be corrected by the PI of reviewing the Can Not Locate (CNL)'s each month with the department managers. See Attachment No 2.
- Staff education and competence evaluations are completed annually and copies are kept in the facility Education Department and Biomedical Shop. A copy may be provided upon request.
- The monitoring, reporting and investigating of medical equipment incident activities are included in the monthly EOC committee report as appropriate. There were no incidents to report for 2011 involving medical equipment.

- The 2011 Performance Improvement goal for Medical Equipment Management was to decrease the percentage of CNL's. This goal was achieved by meeting with the department managers on a monthly basis to resolve the CNL's. This goal was accomplished as evidence by an annual CNL percentage for 2011 of .9% compared to prior year of 1.4%. See Attachment No 1.

Effectiveness

Overall, the Plan as designed has been very effective to date in the management of medical equipment risks. It has also resulted in the safe and effective use of medical equipment by ensuring that the equipment is appropriate for the intended use, staff members are trained to use the equipment safely and effectively, and qualified individuals appropriately maintain the equipment. As such, it has effectively accomplished the stated objectives of the Plan. In addition, the program outcomes delineated provide additional evidence of the overall effectiveness of the Plan.

Although process improvement goals have been attained and the Plan is obviously effective as indicated, making the recommended changes will ensure that the Plan is up to date and continues to be effective.

Recommendations

As in 2011, focus-monitoring efforts for 2012 will be on the following for Medical Equipment Management:

- Medical equipment selection and acquisition process
- Risk/Inventory Criteria
- Inspection, Testing, and Maintenance Strategies, Intervals, and Outcomes as appropriate
- Safe Medical Devices Act monitoring and reporting activities
- Medical Equipment Emergency Procedures Education
- Life support equipment
- Education/Staff Competence
- Monitoring, reporting, & investigating medical equipment incidents
- Achieving a Performance Improvement goal for 2012 of decreasing Open Case Total from 62 to less than 10

This will ensure that the process remains in consonance with the requirements of EC.04.01.01.

Attachment No. 1

Aggregate Planned Maintenance Compliance Summary

Palmyra Medical Center

131190

Report Period: December, 2011 | Date Printed: 2/8/2012

Biomed Planned Maintenance Inventory	1,504	1,502	1,499	1,497	1,491	1,530	1,529	1,517	1,506	1,510	1,504	1,518	18,107	9,084
Biomed Compliant Devices	1,433	1,436	1,466	1,453	1,455	1,461	1,472	1,478	1,469	1,473	1,467	1,478	17,541	8,837
Biomed Compliant Percentage	95.3%	95.6%	97.8%	97.1%	97.6%	95.5%	96.3%	97.4%	97.5%	97.5%	97.5%	97.4%	96.9%	97.3%
DI Planned Maintenance Inventory	31	31	31	31	30	30	30	32	32	31	31	31	371	187
DI Compliant Devices	31	31	31	31	30	30	30	32	32	31	31	27	367	183
DI Compliant Percentage	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	87.1%	98.9%	97.9%
Total Planned Maintenance Inventory	1,535	1,533	1,530	1,528	1,521	1,560	1,559	1,549	1,538	1,541	1,535	1,549	18,478	9,271
Total Compliant Devices	1,464	1,467	1,497	1,484	1,485	1,491	1,502	1,510	1,501	1,504	1,498	1,505	17,908	9,020
Total Compliant Percentage	95.4%	95.7%	97.8%	97.1%	97.6%	95.6%	96.3%	97.5%	97.6%	97.6%	97.6%	97.2%	96.9%	97.3%
Device In Use	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Device Not Located	23	20	15	16	15	16	16	7	7	11	11	11	168	63
	1.5%	1.3%	1.0%	1.0%	1.0%	1.0%	1.0%	0.5%	0.5%	0.7%	0.7%	0.7%	0.9%	0.7%

Attachment No 2

Annual Planned and Corrective Maintenance Safety Committee Report

Palmyra Medical Center

131190

Report Period: December, 2011 | Date Printed: 2/8/2012

Planned Maintenance Compliance	>95%	95.4%	95.7%	97.8%	97.1%	97.6%	95.6%	96.3%	97.5%	97.6%	97.6%	97.6%	97.2%	96.9%
Planned Maintenance Compliance - Life Support	100%	98.5%	96.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.6%
PM "Device Not Available"		0	0	0	0	0	0	0	0	0	0	0	0	0
PM "Can Not Locate"		23	20	15	16	15	16	16	7	7	11	11	11	168
PM "Pending for Other Reasons"		48	46	18	28	21	53	41	32	30	26	26	33	402
Corrective Maintenance (CM)	Open	86	72	75	68	68	110	109	108	59	84	86	62	987
	Complete	85	64	77	63	66	108	105	104	53	70	86	63	944
Device Alerts / Recalls		0	0	3	0	0	1	0	0	0	1	0	0	5
Could Not Duplicate		4	1	7	6	5	5	7	24	3	5	4	3	74
Operator Error		1	1	3	4	0	3	3	2	2	1	2	3	25
Physical Damage		8	1	10	2	0	4	3	8	4	1	3	4	48
Incident Investigation		0	0	0	0	0	0	0	0	0	0	0	0	0
Acceptance Testing Done - Found In Use		1	2	1	1	0	2	0	0	0	0	1	0	8

Attachment No 3

BMET Name:	Allen Millington
BMET Phone:	229-434-2199
Site Name:	HCA Palmyra Medical Center
CS Zone:	Southeast
Site Code:	131190

Control #	Department	Make	Model	Part Number from PDA	Current Coverage	Requested Coverage	Effective Date Desired	Reason Change is required and/or for the Effective Date Reason
		Ross Laboratories	Patrol		PMNP	FSNP	6/1/2011	18 units to change per Administrative Request
		HuntLeigh Technology	AC550		PMNP	FSNP	6/1/2011	35 units to change per Administrative Request
		HuntLeigh Technology	AC600		PMNP	FSNP	6/1/2011	11 units to change per Administrative Request
		HuntLeigh Technology	Flowtron AC600/US		PMNP	FSNP	6/1/2011	28 units to change per Administrative Request
		HuntLeigh Technology	Flowtron Excel		PMNP	FSNP	6/1/2011	3 units to change per Administrative Request
		Arizant Healthcare	Ranger 245		ESNP	FSNP	6/1/2011	4 units to change per Administrative Request
		Arizant Healthcare	245		ESNP	FSNP	6/1/2011	2 units to change per Administrative Request
		Arizant Healthcare	750		PMNP	FSNP	6/1/2011	23 units to change per Administrative Request
		Arizant Healthcare	850		PMNP	FSNP	6/1/2011	34 units to change per Administrative Request

CFO Name	S. L. Woodford
CFO Signature	[signature] 8/8/11

Attachment No 4

Division: Southeast

Region: Georgia

HCA Palmyra Medical Center

Cases by Activity Types Detail Report All Cases with Parts, by Activity Type, Department

For the Period 01/01/2011-12/31/2011

Activity Type Action Taken	Activity Description	User Dept	Control Number	Make / Model	Description	Case Number	Employee Hours	Vendor Hours	Total Hours
	Recall/Hazard Alert	Anesthesia	400163495	BAXTRV/INFUS OR	Pump/Syringe	2793:45031	0.5	0.0	0.5
	Recall/Hazard Alert	Anesthesia	400163496	BAXTER/INFUSER OR	Pump/Syringe	2792:45031	0.5	0.0	0.5
	Recall/Hazard Alert	Anesthesia	400163580	BAXTRV/INFUS OR	Pump/Syringe	2788:45031	1.5	0.0	1.5
					Count: 3		2.5	0.0	2.5
	Recall/Hazard Alert	Lab	400163715	GFMD/2200	Centrifuge, Tabletop	3169:45031	3.0	0.0	3.0
	Recall/Hazard Alert	Lab	400163768	BECKCO/LH500	Hematology Analyzer	2982:45031	0.5	0.0	0.5
					Count: 2		3.5	0.0	3.5

FIRE SAFETY MANAGEMENT PLAN #2

ANNUAL EVALUATION OF THE EFFECTIVENESS OF THE LIFE / FIRE SAFETY Management Plan (2011)

SCOPE:

The scope of the Life / Fire Safety Management Plan defines the processes which Palmyra Medical Center utilizes to provide an environment that protects patients, staff and visitors, as well as protecting property from fire, smoke and products of combustion.

OBJECTIVE:

The objective of the Life / Fire Safety Management Plan is to design proactive processes to prevent fires and protect patients, staff, visitors and property in the event of a fire.

GOALS:

- The goals of Palmyra Medical Center Life / Fire Safety Management Plan includes the following:
  - To assure that the building is in compliance with applicable NFPA standards for hospitals as well as local fire regulations.
  - To provide education to personnel on the elements of the Life / Fire Safety Management Plan including organizational protocols for response to, and evacuation in the event of a fire.
  - To assure that personnel training in the Life / Fire Safety Management Plan is effective.
  - To test and maintain the fire alarm, detection systems and suppression systems
  - To ensure proper maintenance of life safety features, such as fire and smoke walls and fire doors.
  - To provide and maintain portable fire extinguishers.
  - To investigate and implement actions to correct deficiencies, failures and user errors.
  - To establish processes for identifying deficiencies, performing an investigation and correcting those deficiencies.
  - To institute interim life safety measures during construction or fire alarm or detection systems failures.

ANNUAL EVALUATION OF THE EFFECTIVENESS OF THE LIFE / FIRE SAFETY MANAGEMENT PLAN (continued)

OBJECTIVES:

What are the results of the Environment of Care Committee's review and evaluation of the objectives of the life / fire safety management plan?

The plan was successful in that it decreased life and fire safety issues through staff and vendor education. Fire drill scores and response forms stats increase from last year. All fire safety systems were inspected at 100%. Wall penetrations decreased due the implementation of above ceiling permit and ongoing Building Maintenance program. New evacuation signs were installed throughout the hospital.

The objectives for the life / fire safety management plan for the upcoming year include:

The capacity limits of the Simplex 4020 Fire Alarm panel have been reached, would like to upgrade to a Simplex 4100U for future expansion. Quote on file.

To continue to improve and monitor Fire Alarm response forms, scores and parameters percentages that drop out on the critique sheet.

To continue to improve and monitor wall penetrations with additional pad and pocket scanners for the Building Maintenance Program.

SCOPE:

What are the results of the Environment of Care Committee's review and evaluation of the scope of the life / fire safety management plan?

Inspections, testing and maintenance of all Fire Safety System are satisfactory as evidenced by the overall positive outcome of the inspections, testing and maintenance of the systems.

Fire Drill zone (smoke zones) response requirement (in-house >20%) went from 24.9% in 2010 to 40% in 2011.

2011 Fire Drill scores had an average of 88% where 2010 had a 84.5% average.

The generation of above ceiling permits policy shows a reduction in wall penetrations through inspection of the Building Maintenance Program.

The Building Maintenance Program has been effective in reducing the amount of building deficiencies. Door latching, exit lights, egress, etc.

ANNUAL EVALUATION OF THE EFFECTIVENESS OF THE LIFE / FIRE SAFETY MANAGEMENT PLAN (continued)

The scope of the life / fire safety management plan for the upcoming year includes: (Has something changed, i.e., added new services, responsibilities, physician practices?)

The plan would stay the same until Phoebe Putney plans and policies are adopted by August of 2012.

Please list any items under consideration for addition to the plan at this time:

The upgrade of the Simplex 4020 panel with the Simplex 4100U to for future expansion.

A new scanner for the Building Maintenance program to improve efficiency of the inspections.

PERFORMANCE:

What potential risks/vulnerabilities were found that may impact the safety of the hospital's staff, patients and visitors?

The Fire Panel is maxed out on its capacity (amperage draw and number of addressable addresses) due to additions and alterations to the hospital. There is a potential for system failure. Quote on file.

O.R. and PACU door (4-sets) need to be moved/replaced to accommodate suite square footage requirements on life safety drawings.

Were fire drills conducted on at least a quarterly basis for all personnel, on all shifts, in all areas of every building where patients are treated?

Yes, (ILSM) measures were implemented from March of 2011 to December of 2011, due to Plan for Improvement corrections. Detailed records can be found in the EOC Fire drill book in Plant OPS.

Was performance of all areas during fire drills evaluated per Joint Commission standards?

Yes, with and average score of (88) out of a hundred. Any score below 70 the staff was educated and re-drilled.

Detail of missed scores are below which help determine what needs to be addressed.

% missed out of all fire drills:

1. Respond in 15 seconds or less – 23%
2. Knowledge of relocation – 6%
3. Doors closed – 6%
4. Call made to 2200 (first) – 0%
5. Manual fire station activated (second) – 26%
6. Knowledge of (Pass) – 6%

ANNUAL EVALUATION OF THE EFFECTIVENESS OF THE LIFE / FIRE SAFETY MANAGEMENT PLAN (continued)

7. Knowledge of (RACE) – 13%

8. Knowledge of evacuation – 6%

Were problems identified during the drills? Please explain and include actions taken to resolve the problems:

Yes. Retraining literature given to department manager to educate staff when the score is < 70 and conducted redrill. Instructed staff as to what they got wrong at time of drill. Also the proper use of fire extinguishers, (PASS) is now demonstrated at each drill.

Were the actions taken effective? What was the final resolution?

Yes, 2011 Fire Drill scores had an average of 88% where 2010 had an 84.5% average.

Has the fire safety training and education for personnel were been effective? Explain:

Yes, out of (15) fire drills there was only (1) department drill that scored below a 70 out of a possible 100.

Were the results on the use of life / fire safety measures and quarterly fire drills communicated to the Environment of Care Committee?

Yes.

Were there recommendations from outside agencies (i.e., fire marshal)? Describe:

Yes, monthly by Mark Daniels (consultant), Parrish Consulting and JCAHO. A Plan for Improvement was generated and corrected.

Is there any proposed building construction or equipment changes for the upcoming year? Describe:

Yes, a total building evaluation is planned by Phoebe Putney Health Systems with approved architects and engineers.

Were interim life safety measures implemented during the past year? Describe and evaluate:

Yes, the interim life safety measures were building wide (doors, wall penetrations, ECT.) All deficiencies were put on a PFI list and corrected as of 12-28-2011.

All exits and life areas were maintained in accordance with Life Safety standards.

ANNUAL EVALUATION OF THE EFFECTIVENESS OF THE LIFE / FIRE SAFETY MANAGEMENT PLAN (continued)

When problems or opportunities for improvement have been identified, have actions been taken, documented and evaluated for effectiveness? Please explain:

Yes, a Plan for Improvement. As of 12-28-2011 all PFI's have been competed for the year. Inspections have shown positive results.

What are the results of performance improvement projects selected for the year?

Fire Drill zone (smoke zones) response requirement (in-house >20%) went from 24.9% in 2010 to 40% in 2011.

Through education, Above the Ceiling permits and withholding Vendor payments wall penetrations have decreased.

Has the facility selected processes for monitoring that need the most attention? Please explain:

To continued educating Fire Response procedures through Microsoft outlook and Meditech.

By implementation of the Building Maintenance Program for all building life safety issues.

Any revisions in the life / fire safety management plan performance improvement indicators/measures for the upcoming year?

No, Inspections, testing and maintenance of all Fire Safety System are satisfactory as evidenced by the overall positive outcome of the inspections, testing and maintenance of the systems.

The performance improvement indicators and measures will change from year to year and will be address annually.

Continue to monitor, reduce failures and safety violations through the Building Maintenance System

Were the actions and/or recommendations of the Environment of Care Committee communicated to the Governing Body and all other facility departments / areas at least bimonthly?

Yes, EOC minutes are posted on Palmyra Intranet and in each department. EOC findings are communicated to Administration for review by board.

PLAN/PROGRAM EFFECTIVENESS:

Identify the life / fire safety management plan's strength and weaknesses. (What has been accomplished? What opportunities for improvement were identified?)

Strengths:

I believe the strength is seen in The Fire Safety Systems themselves as meeting 100% of the inspections and overall performance standards year after year.

ANNUAL EVALUATION OF THE EFFECTIVENESS OF THE LIFE / FIRE SAFETY MANAGEMENT PLAN (continued)

Through education fire drill scores and response returns has increased in 2011.

Above the Ceiling permits decrease the deficiencies found during Building Maintenance Inspections.

Weakness:

The weakness is the Fire Alarm panel's current capacity is maxed out due to additions and remodeling project, need to upgrade to a 4100U system. The existing 4020 panel cannot be expanded on. Quotes on file.

What are the goals for the life / fire safety management plan for the upcoming year?

To maintain and improve high scores on fire drills and zone response.

The upgrade of the Simplex 4020 panel with the Simplex 4100U for future expansion.

Would like to see upgrade on Fire Pump, Transfer switch and sprinkler heads.

To reduce the deficiencies found from our Building Maintenance Program.

What financial resources have been allocated toward these goals?

Operating and Capital funds approved through new ownership.

There is ongoing monitoring of performance in the area of actual and potential risks related to the life / fire safety management program. The following performance improvement activities are recommended for consideration by the organization as a priority for improvement and will be forwarded to the Environment of Care Committee and Quality administration.

The upgrade of the Simplex 4020 panel with the Simplex 4100U to for future expansion.

This year through the performance improvement indicators Manual Fire Pull activation fell out as the highest measure (26%) missed during fire drills. This will be 2012 PFI.

The installation of more EVAC maps. New and upgraded signs.

Report completed by: **John Kline** / Clint Perdue **Date:** 1-12

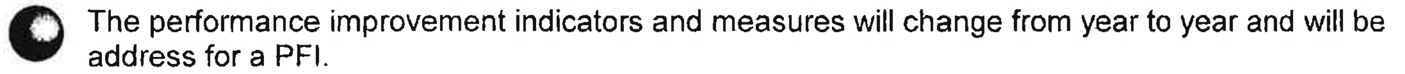
Submitted to Environment of Care Committee **Date: 2-10-12**

Summary:

The average Fire Drill score went from 85.4 in 2010 to 88 in2011.

Fire Drill zone (smoke zones) response requirement (in-house >20%) went from 24.9% in 2010 to 40% in 2011.

ANNUAL EVALUATION OF THE EFFECTIVENESS OF THE LIFE / FIRE SAFETY MANAGEMENT PLAN (continued)



The performance improvement indicators and measures will change from year to year and will be address for a PFI.

UTILITY SYSTEMS MANAGEMENT PLAN #3

2011 ANNUAL EVALUATION OF THE EFFECTIVENESS OF THE UTILITY SYSTEMS MANAGEMENT PLAN/PROGRAM

OBJECTIVES:

What are the results of the Environment of Care Committee's review and evaluations of the objectives of the utility systems management plan/program?

Energy Management, to reduce energy cost by lowering set points to reduce energy cost.

Installation of the second emergency generator and a tank monitoring system was not met due the acquisition of the hospital

The objectives for the utility systems management plan/program for the upcoming year include:

Assess and minimize risks of utility failures

Promote a safe, controlled, comfortable environment of care

Ensure operational reliability of the utility systems

SCOPE:

What are the results of the Environment of Care Committee's review and evaluation of the scope of the utility systems management plan/program?

Approved by the Committee in February 2012 and monitored throughout the year, with no change to the plan

The scope of the utility systems management plan/program for the upcoming year include: (Has something changed? i.e., added new services/responsibilities, physician practices)

Evaluation of all major utility systems in the entire facility by the Albany-Dougherty Hospital Authority

Please list any items under consideration for addition to the plan/program at this time:

Installation of a second emergency generator and also install UV lighting protection in select air handlers.

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ANNUAL EVALUATION OF THE EFFECTIVENESS OF THE UTILITY SYSTEMS MANAGEMENT PLAN/PROGRAM (continued)

PERFORMANCE:

Are Utility System Failure/User Error Reports maintained and reported to Environment of Care Committee at least quarterly? Please explain:

Yes, reported bi- monthly, Environment of Care Committee minutes are recorded and documented and are on the Palmyra Intranet for all departments.

Have there been any user errors/accidents over the course of the past year? Please explain and include actions taken to prevent recurrence:

None for the past year

When problems or opportunities for improvement have been identified? Have actions been taken, documented and evaluated for effectiveness? Please explain:

Weekly rounding though mechanical spaces at 98% completion

What are the results of performance improvement projects selected for the year? How did these projects affect patient care delivery?

Weekly Rounds cut down on any problems effecting patient care areas. Also maintaining environmental control by monitoring equipment more closely.

Has the facility selected processes for monitoring that need the most attention? Please explain.

Weekly rounds though mechanical spaces and the plant to document readings. Also to monitor equipment finding failures or problems before they arise.

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ANNUAL EVALUATION OF THE EFFECTIVENESS OF THE UTILITY SYSTEMS MANAGEMENT PLAN/PROGRAM (continued)

Any revisions in the utility systems management plan/program performance improvement indicators/measures for the upcoming year?

Successful weekly rounding though mechanical spaces and Plant to record readings. In 2012, to cut work order response time to 30mintues when received by Plant Operation technician.

PLAN/PROGRAM EFFECTIVENESS:

Identify the utility systems management plan's/program's strengths and weaknesses (What has been accomplished, what opportunities for improvement were identified?):

Successful Joint Commission Survey in 2011 findings in the Utility Management was medical gas deficiencies, problems were found and corrected, successful weekly rounds though mechanical spaces, PM's 100% completion on all major utilities, and major generator repairs were done in 2011

.weakness: maintaining older equipment, availability of parts (MCC for example awaiting to

Finish new MCC project projected completion for 2012

What are the goals for the utility systems management plan/program for the upcoming year?

With acquisition pending purchases were limited in 2011. With a total evaluation of the utilities for the facility to better serve patient care

Additional emergency generator to be added to the facility for environmental control and additional fuel supply tank for longer run time

What resources have been allocated toward these goals?

Have had building surveyed by Noven, PSP building architects, Invision Advantage Engineering and awaiting approval and decisions of the new owners of the hospital.

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ANNUAL EVALUATION OF THE EFFECTIVENESS OF THE UTILITY SYSTEMS MANAGEMENT PLAN/PROGRAM (continued)

There is an ongoing monitoring of performance in the area of actual and potential risks related to the utility systems management plan/program. The following performance improvement activities are recommended for consideration by the organization as a priority for improvement and will be forwarded to the Environment of Care Committee, Quality Department and to Administration. Program changes initiated in response to evaluation.

All patient care work orders response time under 30 minutes upon time of received by the Plant Operations department.

Report completed by Jason Guined on February 1, 2012

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ENVIROMENTAL SAFETY MANAGEMENT PLAN #4

Annual Evaluation
For year ending 2011
Environmental Safety Management Plan

Scope

The scope of the Environmental Safety Management Plan encompasses all required processes as identified in the appropriate Joint Commission, NFPA, OSHA, and other applicable regulatory codes and standards. The scope also includes all of the buildings, grounds, equipment, services, and staff of the organization, as well as our patients, visitors, vendors, contractors, and the general public who use our facilities.

While Safety and Security have been combined in the standard, the plan and evaluation will be done separately as they are assigned to two different individuals. Other changes to the standards have not resulted in the need for changes to our current scope. As such, further revisions in scope should not be required based on these changes.

In addition, there have not been any changes to other applicable laws and/or regulations or to the organization and/or its mission (no new services, programs, sites, or hazards) that would necessitate further changes in scope to the Plan. While new services have been added, the scope already covered all services.

Objective(s)

The basic objectives of the Plan for last year were to:

- Identify inherent safety risks associated with providing services for patients, the performance of daily activities by staff, and the physical environment in which services occur; and

- Plan and implement processes to minimize the likelihood of those risks causing incidents.

These are still considered to be valid objectives for the upcoming year.

In determining the overall effectiveness of the Plan and the effectiveness of the Plan in relation to the stated objectives, the following elements and/or program outcomes will be evaluated.

- Risk identification process and actions taken to address identified risks;
- Maintenance of grounds & equipment;
- Product Notices & Recalls;
- No Smoking Policy;
- Education/Staff Competence;

- Monitoring, reporting, & investigating activities;
- Environmental Tours
- Physical Environment management activities as applicable/appropriate; and
- Performance Improvement activities

Performance

Overall, the processes utilized in the Plan worked well as evidenced by the Program outcomes delineated herein.

Element	Outcome
Risk Assessment to identify and address identified risks	Assessment completed 1/26/2011 by safety committee. Every area both inside and outside facility evaluated and scored based on potential for patient injury, personal harm, environmental hazard, fire prevention hazard and other special hazards. A score for each area based on the risk potential was determined and a surveillance assignment and interval was given to address the potential risks.
Maintenance of Grounds and Equipment	Grounds and equipment maintenance conducted and reported to environment of care committee quarterly. All identified issues appropriately addressed.
Product Notices and Recalls	All product notices and recalls now being logged on spreadsheet on public drive and a summary report is submitted to the safety sub-committee each quarter. Both pharmaceutical and non-pharmaceutical product recall compliance is 100% for 2011. (Items removed, returned, or other appropriate action taken)
No Smoking Policy	Compliance monitored during security rounds. When non-compliance with policy is noted appropriate action taken by staff. Data on number of occurrences of non-compliance is now being collected by the security department and reported to EOC.
Education/Staff Competence	Annual competency for Safety was provided through the EverReady education packet. All employees were required to complete the packet and compliance was 100%. Employee update completion including safety education was monitored and found to be 100% compliant. Orientation of new employees regarding safety was at 100% compliance.
Monitoring, Reporting, and Investigating activities	The Environment of Care committee monitors many different elements of safety and takes corrective action when needed. The results of this monitoring, reporting and investigating are then reported to EOC for inclusion

	where appropriate to the Board, Medical staff, and facility. The risk manager investigates all occurrence reports and safety complaints and appropriate action and/or reporting is taken and appropriately documented.
Environment of Care Committee Activities	EOC meets bi-monthly to analyze safety data along with all other EOC functions and data, address any safety concerns, and discuss corrective action when applicable. In addition, the Infection Control Nurse is responsible for the environmental rounds team and the completion of the rounds and any necessary corrective action. The EOC also reviews safety policies, performs annual risk assessment, and annual safety plan evaluation.
Physical Environment Management	Pre-construction risk assessments completed and percent compliance reported. 100% compliance for 2011.
Performance Improvement	Safety committee PI report for safety is attached to this evaluation.

As in 2011, monitoring efforts for Safety Management in 2012 will focus on:

- Injuries to patients or others within the hospital's facilities;
- Occupational illnesses and staff injuries; &
- Physical environment and opportunities to reduce risk.

Effectiveness

Overall, the Plan as designed has been very effective to date in both identifying and addressing inherent safety risks associated with providing services for patients, the performance of daily activities by staff, and the physical environment in which the services occur. As such, it has effectively accomplished the stated objectives of the Plan. In addition, the program outcomes delineated provide additional evidence of the overall effectiveness of the Plan.

See attached process improvement for safety for a detailed analysis of items monitored in 2011 and outcomes of that monitoring and corrective action where indicated.

Although process improvement goals have been attained and the Plan is obviously effective as indicated, making the recommended changes will ensure that that the Plan is up to date and continues to be effective.

Recommendations

1. Continue to monitor all of the buildings, grounds, equipment, services, and staff of the organization, as well as our patients, visitors, vendors, contractors, and the general public who use our facility.
2. Continue to identify inherent safety risks associated with providing services for patients, the performance of daily activities by staff, and the physical environment in which services occur and plan and implement processes to minimize the likelihood of those risks causing incidents.
3. Continue to monitor performance improvement (see attached performance improvement data for specific items that will be monitored in 2012).

   As in 2011, focus monitoring efforts for 2012 on the following for Safety Management:

   - Injuries to patients or others within the hospital's facilities;
   - Occupational illnesses and staff injuries; &
   - Physical environment and opportunities to reduce risk

Palmyra Medical Center

Performance Improvement Measurement Trend Report for 2011 **Function: Safety**

INDICATOR NUMERATOR/DENOMINATOR	Bench Mark	Last Year	1st QTR	2nd QTR	3rd QTR	4th QTR	CONCLUSION/RECOMMENDATION/ ACTION/FOLLOWUP (NP – not performed)
Education: Numerator - Employee update complete Denominator - Total number of employees required to complete update	100%	100%	100%	100%	100%	100%	**Annual:** 100% Will continue to monitor due to regulatory compliance.
Numerator – Employee training Standards Compliance (number of employees who completed orientation education) Denominator – Number of employees required to complete orientation	100%	99%	100%	100%	100%	100%	**Annual:** 100% Will continue to monitor due to regulatory compliance.

Palmyra Medical Center

Performance Improvement Measurement Trend Report for 2011 **Function: Safety**

INDICATOR NUMERATOR/DENOMINATOR	Bench Mark	Last Year	1st QTR	2nd QTR	3rd QTR	4th QTR	CONCLUSION/RECOMMENDATION/ ACTION/FOLLOWUP
Product Recalls: Numerator – Total number of recalls with appropriate action taken Denominator - Total number of products recalled	100%	100% 62/62 Non-pharm 13/13 pharm	100% 184/184 non pharm 40/40 pharm	100% 14/14 non pharm 2/2 Pharm	100% 8/8 Non-pharm 5/5 pharm	100% (9/9) Non-Pharm 2/2 Pharm	**Annual:** 100% Will continue to monitor due to regulatory requirements and clinical significance **Annual:** 94% Continue to monitor due to regulatory requirements, goal not met, and safety significance. See attached report for details
Environmental Rounds: Numerator - Departments with documentation of environmental rounds conducted Denominator - Total number of departments required to complete environmental rounds	100%	91%	91%	86%	100%	100%	1st qt: email notification sent out to all outstanding departments.. 2nd qt – see attached report for details of action taken 3rd and 4th qt issues noted on rounds – ceiling tiles but this is improved and storage of cardboard Boxes- sent house-wide email on both

Palmyra Medical Center

Performance Improvement Measurement Trend Report for 2011 **Function: Safety**

INDICATOR NUMERATOR/DENOMINATOR	Bench Mark	Last Year	1st QTR	2nd QTR	3rd QTR	4th QTR	CONCLUSION/RECOMMENDATION/ ACTION/FOLLOWUP
Radiation Safety: **Dosimetry exposure rate** Numerator - # of employees within acceptable limits Denominator - # required to be tested	100%	N/A	100% (51/51) 0 ALARA	100% 0 alara	96% 3 ALARA	92% 4 ALA RA	**Annual:** 97% Continue to monitor – goal not met and safety significance **Annual:** 95% Continue to monitor – goal not met and safety significance Nuclear med quarterly review conducted January 11, 2011 and FDA MSQA Inspection Mammography on April 6, 2011 and both found to be in compliance. 1st qt badge compliance: Individuals not wearing badges counseled. Will monitor for trends. 2nd qt badge compliance: During radiation safety meeting on 6/21/11 the badge program was reviewed, a "champion for each area was named" and it was reported that badge holders had been mounted in OR, RAD, and US. 3rd qt exp rate and bade compliance-individual counseling An email will be sent to Rad director for corrective action and will continue to monitor in 2012.
Dosimetry badge compliance Numerator - Number of employees compliant with wearing and returning badge Denominator - Total number of employees required to wear and return badge	100%	96% 199/207	96%	95% 178/187	95%	95%	

Palmyra Medical Center

Performance Improvement Measurement Trend Report for 2011 **Function: Safety**

INDICATOR NUMERATOR/DENOMINATOR	Bench Mark	Last Year	1st QTR	2nd QTR	3rd QTR	4th QTR	CONCLUSION/RECOMMENDATION/ ACTION/FOLLOWUP
Employee Health: Numerator - Number of times procedure followed and appropriately documented for employee injury/illness Denominator - Number of occurrences	<PY	NM	NM	90% 9/10	75% 6/8	89% 8/9	See quarterly report for more detail and other measures. Beginning 2nd qrt reporting changed with new HR leader. For 2nd qt had one employee enter occurrence late and for 3rd had 2 late occ health visits and entering report late. Verbal counseling done for all.
Numerator - # of sharps injuries reported Denominator - Avg daily census	<PY	0.15	0/77=0.00	1/86=0.01	2/83=0.02	6/76=0.08	**Annual Avg** – 0.03 See infection control report for details

Palmyra Medical Center

Performance Improvement Measurement Trend Report for 2011 **Function: Safety**

INDICATOR NUMERATOR/DENOMINATOR	Bench Mark	Last Year	1st QTR	2nd QTR	3rd QTR	4th QTR	CONCLUSION/RECOMMENDATION/ ACTION/FOLLOWUP
Laser Safety: Numerator - Number of times laser protocol followed Denominator - Total number of cases where laser was used	100%	100% (31/31)	N/A	N/A	N/A	N/A	NOTE: Laser safety will be removed from this report as it is no longer applicable. No lasers have been done since Oct 2010 when Dr. Dixon retired. The equipment is no longer in use.
Infection Control: Numerator- # of times construction assessments done per policy Denominator- # of construction permits issued	100%	100% (30 plus 4th qt #)	100%	100%	100%	100%	**Annual**: 100% continue to monitor due to safety/infection control

Palmyra Medical Center

Performance Improvement Measurement Trend Report for 2011 **Function: Safety**

INDICATOR NUMERATOR/DENOMINATOR	Bench Mark	Last Year	1st QTR	2nd QTR	3rd QTR	4th QTR	CONCLUSION/RECOMMENDATION/ ACTION/FOLLOWUP
Grounds: <u>Numerator</u> - Number of times grounds inspections done as required with appropriate corrective action if indicated <u>Denominator</u> - Total number of times grounds inspection due	100%	100%	100%	100%	100%	100%	**Annual:** 100% - continue to monitor due to safety significance

Environment of Care Quarterly Report

EOC Function: Safety: Education (2011)

Indicator Measures

	Indicators (Include definition of rate calculation if applicable)	Quarter / Year: ____4th 2011________			Prior Qtr	Same period prior year.
		Actual	Expected	Var.		
1	Employee Update Percent of Completion	100	100%		100%	
2	Mandatory Safety Courses Completion(2011EverReady Packet)	100%	100%		100%	
3	Employee Training Standards Compliance(Orientation Education)	100%	100%		100%	
4	Staff Education / Training % Completion(New/Updated Equipment Education)	100%	100%		100%	
5	Occurrence Reports Percent Analyzed	100%	100%		100%	
6						
7						
8						

B: Indicator Analysis (Should reflect analysis of indicators

		Problems/Failure/Errors	Corrective Action
1	Employee Update Percent of Completion	None Identified	
2	Mandatory Safety Courses Completions(2011EverReady Packet)	None Identified	2011 EverReady packet has been revised and was utilized as an update for all existing employees and is being given to all new employees during General Orientation
3	Employee Training Standards Compliance(Orientation Education)	None identified	Directors, HR, Education working together to monitor this Indicator.
4	Staff Education / Training % Completion(New/Updated Equipment Education)	None Identified	(See attached report of training offered.)
	Occurrence Reports Percent Analyzed	none	All new hires are being educated by Risk Manager on Occurrence Reporting and how they are analyzed.

4th Quarter 2011 Safety Education Programs/Classes

1. 2011EverReady Employee Annual Education Update being used in staff and Student Orientation
2. Alaris pump Education Continued with new staff members.
3. Equipment education done with all new Nursing personnel and other staff members ongoing and as need
4. ACLS/PALS classes offered with very good attendance
5. Accu-check monitor training done for all new nursing employees
6. Meditec training being done for Nursing Orientees.
7. DVT and Low Molecular weight based heparin's education
8. Medication usage in-service
9. Meditec Documentation of Occurrence Reports
10. Medication Safety is being presented at every Nursing Orientation Class
11. HCAHPS Hospital Survey Education presented to staff
12. I-care Education has been integrated into General Orientation
13. Code Cart Education done in orientation
14. Fall Prevention Program presented in Orientation
15. 12 Lead EKG
16. BTCA
17. Medication Administration safety

21. Laser Safety
22. Hand Hygiene
23. Competency Days done for clinical and Non-clinical Staff in ED
24. EMTALA Education
25. Bowel Management System Education done for all Nursing Units
26. Sterilizer Qualification Testing Using Process Challenge Devices
27. Suicide Prevention Plan education
28. CVC Pick Lines
29. ERCP Staff Education
30. Using Observation and Audit Tools to Improve Quality Outcome
31. Meditec Updates
32. 2011 Employee Update(EverReady) completed by all existing employees
33. CPR Update
34. Diabetes Update
35. Emergency Code Cart Education
36. Equipment Failure Plan
37. Stopping the spread of MRSA
38. Safety in the CSR Department
39. Restraint Education
40. Foley Catheter Related Infections
41. Documentation Legalities
42. Care of the Endoscopy equipment
43. Steam Sterilizers
44. Radiations Rights
45. Proper usage of Bariatric equipment
46. I-Care Training for Department Managers and Staff
47. Influenza Education
48. Lifting and Transferring Education
49. Size Wise Low-Boy Bed
50. Sepsis
51. Trauma Nurse Core course
52. PMC Interpreters/Translators and Accommodating Individuals with Special Needs

Environment of Care Quarterly Report

EOC Function: Safety: Product Recalls

Indicator Measures

	Indicators (Include definition of rate calculation if applicable)	Quarter / Year: 4th QTR 2011			Same period last year	Trending noted (Y/N).
		Actual	Expected	Var.		
1	% Product recalls received and appropriate action taken	9/9	100%	0	100%	N
2	% pharmaceutical recalls received and appropriate action taken	2/2 100%	100%	0	100%	N

B: Indicator Analysis (Should reflect analysis of indicators

		Problems/Failure/Errors	Corrective Action
1	% Product recalls received and appropriate action taken	N/A	N/A
2	% pharmaceutical recalls received and appropriate action taken	N/A	N/A

Additional Comments, Projects, Activities:

Environment of Care Quarterly Report

EOC Function: Safety: ENV. Rounds and Infection Control

Indicator Measures

	Indicators (Include definition of rate calculation if applicable)	Quarter / Year: 4th qt 2011			Same period last year	Trending noted (Y/N).
		Actual	Expected	Var.		
1	% Environmental rounds conducted	100%	100 %	0%	75%	N
2	% Environmental rounds (Follow Up from previous quarter)	92%	100%	-43%	68%	Y
3	% Construction assessments done per policy (total 2 permits granted)	100%	100%	0%	100%	N

B: Indicator Analysis (Should reflect analysis of indicators

		Problems/Failure/Errors	Corrective Action
1	% Environmental rounds conducted	Turing in environmental rounds and follow-ups in a timely and correct manor.	• Notifications will be sent to all outstanding departments via Outlook, Phone call, face to face
	Main issues noted among 4th Quarter surveys	1. Ceiling tiles stained or cracked is an ongoing issue, but compared to previous reports an improvement has been noted. 2. Storage of corrugated cardboard. Issue is being transitioned slowly but surely, will continue to monitor.	1. Send out a house wide notification regarding the need for reporting damages tiles. 2. Send out a house wide notification regarding the need to eliminate storage of corrugated cardboard.
4	% Construction assessments done per policy	100% of construction assessments were completed per policy. A multidisciplinary approach is need to ensure construction sites are permitted correctly.	N/A Will set up a meeting with Plant Operation and Infection Control to review future construction projects.

Additional Comments, Projects, Activities:

An environmental rounds team has been developed. Participants have been instructed on how to perform the survey. Participants do not survey their own area. Currently participation is good.

Note: 4th Q Environmental rounds statistics represents 7 out of 7 rounds =100% compliance

[illegible]llow-up: 3rd Quarter Environmental rounds (Follow Up) 92% (33 out of 36) Will follow up on lack of [illegible]mpliance

Environment of Care Quarterly Report

EOC Function: Safety: Radiation

Indicator Measures

	Indicators (Include definition of rate calculation if applicable)	Quarter 4/ Year: 2011			Same period last year	Trending noted (Y/N).
		Actual	Expected	Var.		
1	Dosimetry Badge Compliance (%compliant with wearing badge)	95%	100 %	+2%	93%	no
2	Dosimetry exposure rate (# w/in acceptable range /#employees required to be tested)	92%	100%	6%	98%	no
3	Dosimetry badges submitted in a timely manner (# badges monitored/# returned w/in 2 months)	87%	100%		Not monitored in 2010	no
4						

B: Indicator Analysis (Should reflect analysis of indicators

		Problems/Failure/Errors	Corrective Action
	Dosimetry Badge Compliance(# Unused badges scheduled /total # monitored))	May -4unused & scheduled 92% June -3 94% July-0 53 badges distributed	
2	Dosimetry exposure rate (# w/in acceptable range /#employees required to be tested)	4 ALARA for quarter April - 1 July -1 Sept - 1 Nov - 1 49 staff monitored	Individual counseling
3	Dosimetry badges submitted in a timely manner (# returned w/in 2 months/# badges monitored)	August 45-94% Sept39-80% Oct 45-92% Nov 43-88% 49 staff monitored	
4			

Additional Comments, Projects, Activities:

Nuclear Medicine Quarterly Review - October 26, 2010- In compliance

Imaging Services Annual Physicist Survey - October 27, 2010- In compliance

Submitted by: Linda Palardy RT, January 18, 2011

Environment of Care Quarterly Report

EOC Function: Safety: Employee Health

Indicator Measures

	Indicators (Include definition of rate calculation if applicable)	Quarter / Year: 4rd qtr 2011			Same period last year	Trending noted (Y/N).
		Actual	Expected	Var.		
1	Employee injury/illness (# of notifications of injury or illness/# of employees)	9/9 100%	100%	0		N
2	Procedure followed and documentation appropriate for injury/illness (# with appropriate documentation/ # of occurrences)	8/9 89%	100%	(11%)		N
3	Sharps injury (# of notifications of sharps injury / # of employees)	0	100%	0		N
4						

B: Indicator Analysis (Should reflect analysis of indicators

		Problems/Failure/Errors	Corrective Action
1	Employee injury/illness (# of notifications of injury or illness/# of employees)	N/A	N/A
2	Procedure followed and documentation appropriate for injury/illness (# with appropriate documentation/ # of occurrences)	1 Late occurrence report	Employee is an HCA employee, but works for corporate. EE was not actually on Palmyra's payroll, but file claimed an forwarded to Corp. office.
3	Sharps injury (# of notifications of sharps injury / # of employees)	N/A	
4			

Additional Comments, Projects, Activities:

HAZARDOUS MATERIALS AND WASTE MANAGEMENT PLAN #5

2011 ANNUAL EVALUATION OF THE EFFECTIVENESS OF THE HAZARDOUS MATERIALS AND WASTE MANAGEMENT PLAN/PROGRAM

SCOPE:

What are the results of the EOC Committee's review and evaluation of the scope of the hazardous materials and waste management plan/program?

Program provides safe environment and assures proper handling, storage and disposal of hazardous materials.

The scope of the hazardous materials and waste management plan/program for the upcoming year includes:

Provide a safe environment for the buildings, grounds, equipment, services, and staff of the organization, as well as our patients, visitors, vendors, contractors, and the general public who use our facilities.

Transition and educate Phoebe North Staff on use of Phoebe Main's existing Haz Mat soft-ware.

OBJECTIVES:

What are the results of the Safety/EOC Committee's review and evaluation of the objectives of the hazardous materials and waste management plan/program?

Identified chemicals in facility and obtained MSDS and updated Haz-Soft for all. Provided education for staff at orientation, on update and educate, in healthstream, and as needed from occurrence reports, environmental rounds, etc.

The objectives for the hazardous materials and waste management plan/program for the upcoming year include:

Update education and training of staff.
Review and update Haz-Soft Intranet site.
Review and update the process for identification, selection, handling, storage, use and disposal of hazardous materials and wastes.
Transition and educate Phoebe North Staff on use of Phoebe Main's existing Haz Mat soft-ware.

GOALS:

What are the goals for the hazardous materials and waste management plan/program for the upcoming year?

Provide safe work environment by identifying all hazardous materials used in the facility and maintaining accurate MSDS inventory.
Ensure staff education on appropriate handling of hazardous materials via orientation, healthstream, and environmental rounds.
Transition and educate Phoebe North Staff on use of Phoebe Main's existing Haz Mat soft-ware.
Obtain complete data on Waste Disposal from Stericycle.

ANNUAL EVALUATION OF THE EFFECTIVENESS OF THE HAZARDOUS MATERIALS AND WASTE MANAGEMENT PLAN/PROGRAM (continued)

PERFORMANCE:

What potential risks/vulnerabilities were found that may impact the safety of the hospital's staff, patients and visitors?

Possible risks/vulnerabilities noted in staff's failure to properly order products "with" the MSDS attached.

Possible risks/vulnerabilities noted in staff's failure to properly utilize "Haz-Soft" software on the hospital's intranet.

Performance Improvement for 2012- educate new and present staff on Haz Mat ordering procedures and how to properly utilize HazSoft.

Are there Material Safety Data Sheets (MSDS) for each product?

Yes- Currently, MSDS's are obtained and maintained for any and all materials defined as "hazardous".

Are there MSDS's posted in both the areas of storage and the areas of use?

MSDS information is available on Palmyra's Intranet under the Haz-Soft icon.
A Master MSDS book of all hazardous chemicals used in this facility is kept in the Emergency Department.

Is an MSDS initiated at the time of entry into the hospital and completed when the product is either disposed of or consumed?

Hazardous chemicals have MSDS at time of order and accompanied with the product.
MSDS are kept on-hand with re-ordered products.

Does the EOC Committee consistently track the entry and exit of all hazardous materials in use in the hospital?

A minimal by-monthly report is presented to the EOC.

Are staff who use the hazardous materials trained in appropriate use?

Hazard communication and hazardous materials and waste management training is provided at orientation and annually thereafter to all associates and volunteers. This is part of a structured staff development program that includes identification, selecting, handling, storing, using, and disposing of hazardous materials supplemented by organizational experience.
Occurrence report training is provided at orientation and annually thereafter to all employees and volunteers. Each employee is provided department and job-specific-related hazards training which is documented in his/her individual educational file.

ANNUAL EVALUATION OF THE EFFECTIVENESS OF THE HAZARDOUS MATERIALS AND WASTE MANAGEMENT PLAN/PROGRAM (continued)

Are all hazardous materials stored in accordance with applicable law and regulation?

Yes-All flammable chemicals are stored in Fire-Proof cabinets.
All chemicals are stored off the floor.

Have hazardous materials currently in use been evaluated for less toxic alternatives? Have any hazardous materials been deleted from use for less toxic alternatives?

Hazardous materials are reviewed and evaluated and no deletions were made for 2011

Have there been any user errors/accidents over the course of the past year?

No accidents or spills occurred for 2011

Were the actions taken effective in preventing recurrence?

N/A

Have problems been identified in the handling/disposal of hazardous wastes? Have actions been taken, documented and evaluated for effectiveness?

No problems noted.

Were the actions taken effective in resolving the problem?

N/A

Are policies and procedures for the selecting/handling/storage/disposal of hazardous wastes consistently followed?

The policies and procedures were followed properly and as a result no accidents or spills were reported for 2011.

Does the Infection Control Committee have consistent input into the management of hazardous wastes?

The Infection Control Committee gives input by reporting on environmental rounds.

Are staff who are exposed to hazardous wastes trained in appropriate handling/disposal?

Each employee is provided department and job-specific-related hazards training by supplier utilizing MSDS.

ANNUAL EVALUATION OF THE EFFECTIVENESS OF THE HAZARDOUS MATERIALS AND WASTE MANAGEMENT PLAN/PROGRAM (continued)

What are the results of performance improvement projects selected for the year? How did these projects affect the use of hazardous materials and waste in the facility? Staff safety?

The staff knowledge of MSDS and availability of updated chemical inventory is satisfactory.
No adverse affect in use of hazardous materials.
Staff safety is satisfactory.
Total walk-thru inventory taken and reviewed…10 chemical products found without MSDS and also not found on Haz-Soft site…correction made.

Any revisions in the hazardous materials and waste management plan/program performance improvement indicators/measures for the upcoming year?

Performance Improvement for 2012- educate new and present staff on Haz Mat ordering procedures and how to properly utilize HazSoft.

Were the actions and/or recommendations of the EOC Committee communicated to the Governing Body and all other facility department/areas at least bimonthly?

Yes…EOC minutes are posted on PMC Intranet site and in each department.

EOC findings are communicated to Administration for review by Board.

PLAN/PROGRAM EFFECTIVENESS:

Please identify hazardous materials and waste management plan's/program's strengths and weaknesses.

Strengths:
Provides education to staff on the elements of the Hazardous Materials and Waste Management Program
Assures effective staff training in the Hazardous Materials and Waste Management Program.
Identifies, evaluates and inventories hazardous materials and waste generated or used consistent with applicable regulations and laws.
Provides adequate space and equipment for the safe handling and storage of hazardous materials and waste
Establishes emergency procedures to use during hazardous materials and waste spills or exposures
Weaknesses:
Staff's failure to properly utilize the Haz-Soft intranet site.
Education opportunities need to be upgraded.
Products found without MSDS.

ANNUAL EVALUATION OF THE EFFECTIVENESS OF THE HAZARDOUS MATERIALS AND WASTE MANAGEMENT PLAN/PROGRAM (continued)

There is ongoing monitoring of performance in the area of actual or potential risks related to the hazardous materials and waste management plan/program. The following performance improvement activities are recommended for consideration by the organization as a priority for improvement and will be forwarded to the EOC Committee.

Performance Improvement for 2012- educate new and present staff on Haz Mat ordering procedures and how to properly utilize HazSoft.

To ensure that proper and adequate testing of air contaminants and trace anesthesia gases is performed.
Gases that will be monitored include trace anesthesia gases, Formaldehyde, Gluteraldehyde, Xylene, ET0, Phenol, and others identified as potentially hazardous to staff.

Report completed by: Charles Mitchell Date: January 2012

Submitted to Safety/EOC Committee Date: February 2012

Summary:

Haz-Mat and Waste Management Plan/Program proved to be very effective for the past year 2011.

Program provides safe environment and assures proper handling/disposal of hazardous materials.

Phoebe North will continue education and training of staff, update Haz-Soft Intranet site, emergency preparedness, review of safety policies, plans, occurrence reporting, safety / hazardous surveys, hazardous materials, risk management, security, life safety, radiation safety, and equipment & utilities management.

SECURITY MANAGEMENT PLAN #6

2011 ANNUAL EVALUATION OF THE EFFECTIVENESS OF THE SECURITY MANAGEMENT PLAN

SCOPE:

What are the results of the EOC Committee's review and evaluation of the scope of the security program?

Program provides a plan that protects employees, patients and visitors from harm. A risk assessment is conducted to determine the elements of the plan and includes all off-site locations.

The scope of the security program for the upcoming year includes:

Provide a safe environment for the buildings, grounds, equipment, services, and staff of the organization, as well as our patients, visitors, vendors, contractors, and the general public who use our facilities,

OBJECTIVES:

What are the results of the EOC Committee's review and evaluation of the objectives of the security program?

The Security Management Plan offered a safe and secure environment for all patients, visitors, staff and property of this hospital.

The objectives for the security program for the upcoming year include:

Assure safety of staff, patients and visitors.

Review camera locations and add extra cameras on 2nd,3rd and 4th floors to provide better coverage of facility.

Increase lighting in the Emergency Center's parking lot.

GOALS:

What are the goals for the security program for the upcoming year?

To provide education to staff on the elements of the Security Management Plan
To reduce the risk of potential security incidents
To address security concerns of patients, visitors, staff and property
To install better EC parking lot lighting
To work with leadership to secure all outer entrance ways and create a badge access only environment.

2011 ANNUAL EVALUATION OF THE EFFECTIVENESS OF THE SECURITY MANAGEMENT PLAN

Please identify strengths and weaknesses in the Security Management Plan. What opportunities for improvement have been identified?

Strengths:
Improvements made to security car for night-time patrols
Added 10 new cameras to facility
Additional parking lot lights in rear Staff parking lot
Controls access to and egress from sensitive areas (i.e., Pediatrics, ED, Special Care Units, Pharmacy)
Reduces the risk of potential security incidents
Addresses security concerns of patients, visitors, staff and property
Provides education to staff on the elements of the Security Management Plan
Weaknesses:
Areas of the hospital not covered by cameras
Lack of accountability of visitors
Lack of Crisis Prevention Intervention training for staff members in Emergency Department
Due to budget restraints…lack of 2 officers per shift…limited coverage

What goals have been set for the Security Management Plan for the upcoming year?

Maintain a safe and secure environment for the patients, visitors, associates and medical staff.
Identify and evaluate any new areas for security and safety risks.
Create and set up a system to "Guest Pass" all visitors to the facility.

What potential risks/vulnerabilities were found that may impact the security of the hospital, staff, staff and visitors?

Lack of camera coverage in key areas inside and outside the facility.
Increase in 10-13 (mentally unstable) patients in the Emergency Department.
Rear cafeteria and Rehab entrance door problems…unable to secure during business hours.
Low light levels in parking areas.

What actions were taken to lessen the potential of event occurring or lessen the impact?

Extra cameras and DVRs were purchased and installed.

Touch-DATA proximity indicators added to key rounding areas.

Were security rounds conducted according to policy?

Yes- records kept by Chief of Security and Supervisor of Yale Enforcement (Contract Service).

What problems were discovered regarding scheduling of rounds?

The need for extra security officers during certain hours.

Coverage needed in additional rounding areas.

2011 ANNUAL EVALUATION OF THE EFFECTIVENESS OF THE SECURITY MANAGEMENT PLAN

What actions were taken to resolve the problems?

Security Officer schedules were adjusted to assist in better coverage.

Were the actions taken effective in resolving the problems?

Yes- but request for additional officers considered.

Was the annual in-service and continuing education of all staff and those working in sensitive areas completed and documented?

Yes- Each associate is provided department and job-specific-related security training which is documented in his/her individual educational file.

List the major accomplishments of the Security Management Plan over the course of the past year:

Assured a safe and secure work environment for staff and associates.
Identified problems that could result in risk increases.
Additional Lighting added to rear Staff parking lot.
Lock-Down system added to all outer entrance doors.
Spot-light added to Security car.
Adjusted Security schedule for better overall coverage and efficiency.

What problems were identified over the last year?

Identified problem with security coverage areas.
Identified the need for additional security officer coverage.
Identified the need for controlled access in and out of this facility.
Identified the need for better parking lot lighting to decrease vehicle break-in problem.

What actions were taken to resolve the problems?

Security Officer hours were adjusted to assist in correct coverage.
Touch-DATA proximity indicators added to sensitive rounding areas.
Locked and secured all entry ways except main public access.
Added lighting to Staff parking area
Requested additional Albany Police Department patrols for this location.

Were the actions taken effective in resolving the problems?

Yes- this corrected the need for security coverage at certain hours.
Yes- sensitive rounding areas are now covered properly.

Were the actions and or recommendation of the Security Management Plan communicated to the Environment of Care Committee and all other facility departments/areas as appropriate?

Yes- this is done at least by-monthly at the EOC meeting.

2011 ANNUAL EVALUATION OF THE EFFECTIVENESS OF THE SECURITY MANAGEMENT PLAN

What problems or actions were reported back to the Environment of Care Committee by department managers/directors during the past year?

Identified problem with inner office doors being found unsecured.

Identified the need for additional lighting in parking areas.

Identified the need for Security Officers to be more visible throughout the facility.

What financial resources have been allocated toward these goals?

Annual Operations budget monies are applied.

Any revisions in the security program performance improvement indicators/measures for the upcoming year?

Performance Improvement- Increase frequency of CODE GRAY drills

Performance Improvement- initiate a system to identify visitors and control public access.

Report completed by: Charles Mitchell **Date:** February 2012

Submitted to Environment of Care Committee **Date:** February 2012

STATE OF GEORGIA
COUNTY OF DOUGHERTY

AFFIDAVIT RELATIVE TO CLOSED MEETING

Personally appeared before the undersigned, RALPH S. ROSENBERG, who having been duly sworn, deposes and states as follows:

1. I am over the age of 18 years, I am suffering under no disabilities and I am competent to testify to the matters contained herein.

2. I am the Chairperson of the Board of the Hospital Authority of Albany-Dougherty County, Georgia (the "Authority").

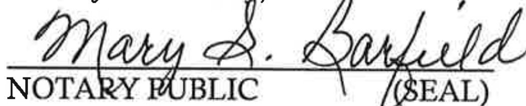
3. On the 16th day of February, 2012, at a meeting of the Authority Board, a motion was duly approved in a roll call vote for the Authority Board to go into closed session for the purposes of: (i) privileged consultation with legal counsel, including consultation pertaining to pending litigation; (ii) the granting, restriction or revocation of staff privileges at Phoebe North (permitted in O.C.G.A §50-14-3(5)); and, (iii) to discuss potentially valuable commercial plans, proposal or strategy that may be competitive advantage in the operation of Phoebe North and/or PPMH (permitted in O.C.G.A. § 31-7-75.2).

4. To the best of my knowledge and belief, the business conducted during the closed portion of the meeting was devoted solely to the above matters for which the meeting was closed.

This the 16th day of February, 2012.

Chairperson

Sworn to and subscribed before me this
16th day of February, 2012.



NOTARY PUBLIC (SEAL)
Dougherty County, Georgia
My Commission expires: 4-11-15